State of Montana

Department of Labor & Industry
Brian Schweitzer, Governor

Employment Relations Division

WC Regulation Bureau
Administration

BEFORE THE EMPLOYMENT RELATIONS DIVISION
OF THE MONTANA DEPARTMENT OF LABOR AND INDUSTRY

APPLICATION FOR SILICOSIS BENEFITS

Instructions: This form is to be used for persons applying for silicosis benefit payments under the Silicosis Benefit Program under Section 39-73-105, MCA. In order to be eligible for such payments, a person must: (1) Have silicosis resulting in total disability, rendering it impossible to continuously follow any substantial gainful manual occupation; (2) Not have a salary exceeding $150 per month; (3) Have resided in and been an inhabitant of Montana for at least ten consecutive years immediately preceding the date of application; and (4) Not be receiving full benefits under the Montana Occupational Disease Act.

I, _____, HEREBY MAKE APPLICATION FOR SILICOSIS BENEFITS.

Date of Birth: _____ SSN: _____.

I HAVE RESIDED IN MONTANA FOR THE PAST TEN (10) CONSECUTIVE YEARS AT THE FOLLOWING ADDRESSES.

At _____ From _____ To _____
At _____ From _____ To _____
At_____From _____ To _____

I WAS EXPOSED TO SILICA DUST DURING EMPLOYMENT AS FOLLOWS:

Employer _____ At _____ From _____ To _____
Employer _____ At _____ From _____ To _____

CURRENT EMPLOYER _____ MONTHLY WAGE _____

OTHER INCOME SOURCES:

Source _____ Amount _____
Source _____ Amount _____
Source _____ Amount _____

YOUR SPOUSE: NAME _____ BIRTHDATE _____

ADDRESS _____

APPLICANT'S SIGNATURE _____ DATE _____

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